DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1100 BIRCH STREET DOUGLAS, WY 82633

RECEIVED
WY Dept of Health
SEP 06 2013
Healthcare Licensing and Surveys

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	K 018	

Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing and New Health Care, of the National Fire Protection Association.

The facility was a fully sprinklered, single story building of Type V (111) construction built in 1967 and 2010. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 60 certified Medicare and Medicaid beds with a census of 57 residents.

K 018 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

K 018

The facility will ensure corridor doors are equipped with latching hardware and ensure corridor doors are smoke resistant in smoke compartments.

1. The conference room with double corridor doors will be equipped with latching hardware.
2. The east solarium corridor door will have the four unsealed circular penetrations filled with putty.

Douglas Care Center (DCC) maintenance man or designee will monitor the facility to ensure all corridor doors are equipped with latching hardware and corridor doors are smoke resistant in smoke compartment. Monitoring will be done on a monthly basis and brought to QA monthly until resolved and then brought to QA on a quarterly basis for up to 12 months to ensure there are no further issues.

9/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NHA | 9/11/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FOC Approved w/ Kelli Fogle, NHA on 9/12/13.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facilities failed to ensure corridor doors were equipped with latching hardware and failed to ensure corridor doors were smoke resistant in 2 of 7 smoke compartments. The findings were: 1. Observation of the conference room on 8/15/13 at 7:56 AM showed the double corridor doors were not equipped with latching hardware. At the time of the observation, the owner could not explain why the corridor doors were not provided with latching hardware. 2. Observation of the east solarium on 8/15/13 at 11:16 AM showed the corridor door had four unsealed circular penetrations. The holes were ¼ inch across. At the time of the observation, the maintenance manager could not explain why the holes had not been noticed and repaired during the quarterly safety inspections.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facilities failed to ensure 2 of 5 smoke barrier walls were smoke resistant. The findings were: 1. Observation of the A wing attic smoke barrier wall on 8/15/13 at 11:35 AM showed there were two unsealed penetrations. The largest hole measured 1 ¼ inches across. At the time of the observation, the maintenance manager confirmed the attic smoke barrier walls were not routinely inspected. 2. Observation of the Alzheimer ' s attic smoke barrier wall on 8/15/13 at 11:45 AM showed there were three unsealed penetrations. The largest hole measured 2 inches by 6 inches. At the time of the observation, the maintenance manager confirmed the attic smoke barrier walls were not routinely inspected.	K 025	K-025 DCC will ensure that all smoke barrier walls are smoke resistant. 1. A wing attic smoke barrier wall will have the two unsealed penetrations sealed. 2. The Alzheimer attic smoke barrier wall will have the three unsealed penetrations sealed. DCC maintenance or designee will monitor all smoke barrier walls and ensure that they are smoke resistant. This will be monitored on a quarterly basis and brought to QA until resolved and then yearly after.	9/15/13
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facilities failed to ensure doors in 3 of 5 smoke barrier walls were smoke resistant. The findings were: 1. Observation of the basement smoke barrier on 8/15/13 at 9:29 AM showed the barrier door was equipped with a magnetic hold open device. Further observation showed a wire was wrapped around the magnetic hold open device and the metal plate attached to the door. The door was not able to be closed without removing the wire. At the time of the observation, the maintenance manager could not explain why the wire had not been noticed and removed during the quarterly safety inspection. 2. Observation of the smoke barrier near resident room #201 on 8/15/13 at 10:41 AM showed one of the double doors was not able to fully latch into the door frame. The self-closing devices attached to the doors were tested three consecutive times. At the time of the observation, the maintenance manager could not explain why the door had not been noticed and repaired during the quarterly safety inspection. 3. Observation of the smoke barrier near resident room #207 on 8/15/13 at 10.45 AM showed one of the double doors was not able to fully latch into the door frame. The self-closing devices attached to the doors were tested three consecutive times. At the time of the observation, the maintenance manager could not explain why the door had not been noticed and repaired during the quarterly safety inspection.	K 027	K 027 DCC will ensure that all smoke barrier walls are smoke resistant. 1. The wire was removed from the basement smoke barrier door. 2. The smoke barrier near resident room #201 with double doors has been fixed so it is able to fully latch into the door frame. 3. The smoke barrier near resident room #207 with double doors has been fixed so it is able to fully latch into the door frame. DCC maintenance or designee will monitor all smoke barrier doors and ensure that they are smoke resistant. This will be monitored on a monthly basis and brought to QA on a quarterly basis until resolved and then monitored monthly after that.	9/15/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4	K 029		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 2 of 7 smoke compartments. The findings were: 1. Observation of the basement wheelchair storeroom on 8/15/13 at 9:04 AM showed the arm to the self-closing device had been removed from the corridor door. Further observation showed a 3 inch by 5 inch ceiling penetration. Review also showed the latching hardware was removed from the corridor door. At the time of the observation, the maintenance manager reported he was unaware storerooms are required to be smoke resistant. 2. Observation of the basement mattress storeroom on 8/15/13 at 9:07 AM showed twenty-three mattresses were stored in the room. Further observation showed the corridor door was not equipped with a self-closing device. Review also	K 029		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 showed three ceiling tiles were out of place, preventing the ceiling from being smoke resistant. At the time of the observation, the maintenance manager confirmed he was unaware rooms converted into storerooms were required to have self-closing devices added to corridor doors. 3. Observation of the basement activities storeroom on 8/15/13 at 9:09 AM showed the corridor door was not provided with a self-closing device. 4. Observation of the basement kitchen storeroom on 8/15/13 at 9:16 AM showed the corridor door was not provided with a self-closing device. 5. Observation of the basement maintenance shop on 8/15/13 at 9:19 AM showed the corridor door was not provided with a self-closing device. Further observation showed there were three wall penetrations. The largest hole measured 3 inches by 4 inches. 6. Observation of the basement medical records storeroom on 8/15/13 at 9:23 AM showed the self-closing device was removed from the corridor door. At the time of the observation the maintenance manager could not explain why the self-closing device had been removed from the corridor door. 7. Observation of the first floor west janitor ' s closet on 8/15/13 at 10:09 AM showed the self-closing device was not able to fully latch the door into the door frame, with three attempts. At the time of the observation, the maintenance manager could not explain why this door was not noticed and repaired during the quarterly	K 029	K 029 DCC will ensure hazardous areas are separated from use areas in smoke compartments. 1. The basement wheel chair storeroom has had the self-closing device and latching device was put back on the corridor door. 2. The basement mattress storeroom has had self-closing devices put on the corridor door and the three ceiling tiles were replaced. 3. The basement activities storeroom had a self-closing device added to the corridor door. 4. The basement kitchen storeroom corridor door has had a self-closing device put on. 5. The basement maintenance shop corridor door has had a self-closing device put on. The three wall penetrations have been repaired as well. 6. The basement medical records storeroom has had a self-closing device added to the corridor door. 7. The first floor west janitor's closet has had the self-closing device latch adjusted so it fully latch's.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 6 inspections.	K 029	K 029 cont. DCC maintenance or designee will audit self-closing devices on all corridor doors on a monthly basis and report to QA quarterly until resolved it will also be added to the monthly safety checks.	9/15/13
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facilities failed to ensure corridors were unobstructed in 1 of 7 smoke compartments. The findings were: 1. Observation of the laundry corridor on 8/15/13 at 9:47 AM showed two bed frames were stored in the corridor. The bed frames reduced the corridor to 3 ½ feet of open space. In new health care occupancies, corridors must be maintained at 8'-0". At the time of the observation, the maintenance manager reported the frames had been stored in the corridor for the past two days. He confirmed that he was aware corridors are required to be unobstructed and accessible. 2. Observation of the Alzheimer's corridor on 8/15/13 at 10:02 AM showed three recliners were stored in the corridor. The chairs reduced the corridor to 5 feet of open space. In new health care occupancies, corridors must be maintained at 8'-0". At the time of the observation, the maintenance manager could not explain why the chairs had not been noticed and removed during the quarterly safety inspections.	K 039	K 039 DCC will ensure corridors are unobstructed in smoke compartments. 1. The laundry corridor has had the two bed frames that were being stored in the corridor removed to ensure there is an 8'-0" space in the corridor. 2. The three recliners stored in the corridor have been removed so there is an 8'-0" space in the corridor. DCC maintenance or designee will in-service staff on keeping corridor areas open to 8'-0". DCC maintenance or designee will also monitor on a quarterly basis and bring to QA until resolved.	9/15/13
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1100 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 7 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facilities failed to ensure fire drills were held at varying times on 1 of 3 shifts. The findings were: Review of the fire drill records showed the second shift occurred between 2 PM and 10 PM. Further review showed the fire drills held over the past year on the second shift all occurred between 2:35 PM and 4 PM. On 8/15/13 at 1:30 PM, the maintenance manager reported he was unaware fire drill were required to be held at varying times throughout the shift.	K 050	K 050 DCC will ensure fire drills are held at varying times on shifts. 1. DCC maintenance or designee will ensure that fire drills are held at unexpected times under varying conditions at least quarterly on each shift. Copies of drills with date and time will be brought to QA on a quarterly basis until resolved.	9/15/13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facilities failed to ensure 2 of 8 fire alarm system components were tested in the past year. The findings were: 1. Review of the fire alarm system testing record showed the system was last tested on 8/13/12. Review showed the fire alarm control panel annual battery discharge test had not been performed in the past year. Further review also showed the semiannual load voltage test had not been performed in the past year. On 8/15/13 at 1:30 PM, the maintenance manager reported he did not have any other records for review. He also reported that he assumed the fire alarm contractor was performing all needed tests. 2. Review of the fire alarm system testing record showed the smoke dampers were not tested during the 8/13/12 annual test. On 8/15/13 at 1:30 PM, the maintenance manager reported he was unaware when the smoke dampers were last tested. Reference NFPA 101, 2000 Edition, 18.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test, ...annually (Replace batteries every 4 years.) 2. Discharge Test, ... annually (30 minutes) 3. Load Voltage Test, ...	K 052	K 052 The facility will ensure that the fire alarm system components are tested on a semi-annual and annual basis dependent on regulation. 1. The annual battery discharge test will be done and on an annual basis. The semi-annual load voltage test will be done and done on a semi-annual basis. 2. The smoke dampers will be tested and tested on annual basis. DCC maintenance or designee will ensure that all tests that need to be done on the fire alarm system components are tested in a timely fashion according to the NFPA 72, 1999 Edition; Testing Frequencies. The reminders will be put into administrator's outlook calendar a month before tests are due to set up with the fire alarm system company.	9/15/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1106 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 9 semi-annually 15. Initiating Devices a. Duct Detectors, ... annually b. Electromechanical Releasing Device (Smoke Dampers), ...annually	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facilities failed to ensure ceilings were smoke resistant to ensure proper sprinkler activation in 1 of 7 smoke compartments and failed to ensure 3 of 7 sprinkler system components were tested. The findings were: 1. Observation of the sprinkler riser room on 8/15/13 at 8:01 AM showed a ½ inch ceiling penetration. The gap will delay the activation of the sprinkler head. At the time of the observation, the maintenance manager could not explain why the hole had not been noticed and filled during the quarterly safety inspections. 2. Observation of the maintenance office on 8/15/13 at 9:11 AM showed a ceiling tile was moved out of place because of a copper water line. The gap measured 1 inch by 24 inches. The gap will delay the activation of the sprinkler head. At the time of the observation, the maintenance manager reported he was unaware ceiling tiles	K 062		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 10 were required to be in place in order to maintain smoke resistant in a fully sprinklered building. 3. Observation of the medical records storeroom on 8/15/13 at 9:23 AM showed a 3 foot by 9 foot section of the ceiling was missing. The sprinkler deflector was more than 12 inches below the top of the exposed ceiling. The sprinkler was 15 inches below the ceiling. At the time of the observation, the maintenance manager reported the ceiling was removed to repair water pipes more than 6 months ago. He could not explain why the ceiling was not repaired after the pipes were replaced. 4. Review of the sprinkler system testing records showed the waterflow alarm and supervisory signal devices had not been tested during the second quarter of 2013 and fourth quarter of 2012. On 8/15/13 at 1:30 PM, the maintenance manager could not explain why the sprinkler system had not been tested on a quarterly basis. He also confirmed there were no other records to review. 5. Review of the sprinkler system testing records showed the backflow preventer had not been tested in the past year. On 8/15/13 at 1:30 PM, the maintenance manager confirmed there were no other records to review. He also reported that he did not have records of the last time the dampers were last tested. Reference NFPA 101, 2000 Edition, 18.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 3-2.7.2 Escutcheon plates used with a recessed or flush type sprinkler shall be part of a listed sprinkler assembly. 5-6.4.1.1 Under unobstructed construction, the	K 062	K 062 DCC will ensure ceilings are smoke resistant to ensure proper sprinkler activation in smoke compartments and ensure the sprinkler system components are tested. 1. The sprinkler riser room that had a ½ inch ceiling penetration has been repaired. 2. The maintenance office ceiling tile has been placed back in its proper place. 3. The medical records store room in the basement has had the 3'-9" section of the ceiling has been repaired. 4. The water flow alarm and supervisory signal devices will be tested on a quarterly basis by Rapid Fire or designee. 5. The sprinkler system will have the backflow preventer tested on an annual basis. DCC maintenance or designee will ensure that ceilings are smoke resistant to ensure proper sprinkler activation in smoke compartments and that the sprinkler system components are tested according to NFPA 25, 1998 Edition.	9/15/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 11 distance between the sprinkler deflector and the ceiling shall be a minimum of 1 in. and a maximum of 12 in. Reference NFPA 101, 2000 Edition, 18.3.5.1, 9.7.5, NFPA 25, 1998 Edition; 9-2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with manufacturer ' s instructions. 9-6.2.1 All backflow preventers installed in fire protection system piping shall be tested annually ... Reference NFPA 101, 2000 Edition, 18.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 15. Initiating Devices j. Supervisory Signal Devices, ... quarterly k. Waterflow Devices, ... quarterly	K 062	K 062 cont. DCC maintenance will bring proper paperwork to QA on a quarterly basis until resolved. Administrator will add dates to outlook calendar to ensure that the testing company and tests are completed when due.	9/15/13
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3	K 074		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure loose hanging fabrics were flame retardant in 4 of 7 smoke compartments. The findings were: Observation on 8/15/13 between 10 AM and 11:30 AM showed the following locations had loose hanging fabrics attached to walls, without flame retardant documentation attached to them or provided in a service log: a. Curtains measuring 4 feet by 4 feet in the Alzheimer ' s corridor work office. b. Curtains measuring 2 feet by 7 feet in the business office. c. Curtains measuring 4 feet by 6 feet in the director of nurses ' office. d. A blanket measuring 4 feet by 5 feet in resident room #211. e. Curtains measuring 4 feet by 5 feet in resident room #111. On 8/15/13 at 11:21 AM, the maintenance manager confirmed the aforementioned fabrics were not flame retardant nor were they sprayed with a flame retardant solution. On 8/15/13 at 11:30 AM, the owner reported that he assumed the curtains did not need to be flame retardant because of Survey and Certification (S&C) letter 12-21. Review of S&C letter 12-21 shows that in certain instances a waiver can be granted by the regional office if loose hanging fabrics are not flame retardant. A waiver cannot be granted before a deficiency has be cited. Reference NFPA 101, 2000 Edition;	K 074	K 074 The facility will ensure loose hanging fabrics are flame retardant in smoke compartments. a. The curtains in the Alzheimer's corridor work office will have flame retardant sprayed on them before being hung back up. b. The curtains in the business office will have flame retardant sprayed on them before being hung back up. c. The curtains in the director of nurses office will have flame retardant sprayed on them before being hung back up. d. The blanket in room #211 has been removed and will be sprayed with flame retardant before being hung back up. e. The curtains in resident room #111 will be sprayed with flame retardant before being hung backup. DCC housekeeping director or designee will do monthly audits on all new curtains or wall hangings to ensure they are sprayed before being hung. Audit results will be brought to QA on a quarterly basis until resolved. Staff will be in-serviced to ensure that if they see family members hanging curtains or wall hangings that they notify housekeeping.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	Continued From page 13 18.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1. (See 19.3.5.5.)	K 074	K 074 cont. A log will be kept of when, and what had retardant sprayed on.	9/15/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facilities failed to ensure junction box covers were provided in 1 of 7 smoke compartments and failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 7 smoke compartments. The findings were: 1. Observation of the medical records storeroom on 8/15/13 at 9:23 AM showed three junction boxes were not provided with cover plates. At the time of the observation, the maintenance manager was unaware when the cover plates were removed. He also reported junction boxes were not routinely inspected to ensure the cover plates were in place. 2. Observation of resident room #117 on 8/15/13 at 11:19 AM showed the refrigerator was plugged into an orange extension cord. At the time of the observation, the maintenance manager could not explain why the extension cord had not been noticed and removed during the quarterly safety inspections. Reference NFPA 101, 2000 Edition, 18.5.1.1,	K 147		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 14 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	K 147 DCC will ensure junction box covers are provided in smoke compartments and will ensure temporary electrical wiring does not replace permanent fixed wired in smoke compartments. 1. The medical records storeroom will have the three junction boxes will be provided with cover plates. 2. Room #117 had the orange extension cord removed that the refrigerator was plugged into. DCC maintenance or designee will monitor the junction box covers on a quarterly basis and bring to QA then until resolved. DCC maintenance or designee will monitor resident rooms for extension cords on a quarterly basis and bring to QA then until resolved. Administrator will also re-educate family about extension cords.	9/15/13